by purgatives were tried out of doors; but on the admission of the patient to hospital, he was placed in a warm bath, then ice was tried, and, finally, chloroform, with no amelioration whatever of the symptoms.

As the sickness continued (though there was no other very pressing symptom to call for operative interference, as Mr. Stanley observed to his class), he decided to operate, as it is always better, he said, to operate too early rather than too late. Every kind and modification of the taxis had failed. Mr. Lawrence agreed with Mr. Stanley in the propriety of operation, as a last resource; Mr. Paget also seemed to be of entirely the same opinion as his colleagues.

The case, as to the seat of stricture, was somewhat doubtful. But if, under the effect of chloroform, the gut did not go back, Mr. Stanley proposed to cut down on the seat of stricture without opening the sac. An incision, accordingly, an inch and a half long, was made, without opening the sac, over the abdominal ring. The operation is, perhaps, thus far an illustration of the fact which is seen every week in hospitals, that there is really no mathematical rule in hernia, as well pointed out especially by Mr. Ward, at the London Hospital, as to opening the sac, or not opening the sac; and that even though we sometimes do not open the sac, one may do mischief by working in the dark; we may thus, for instance, return a portion of sphacelated omentum, or even a bowel on the point of bursting, or, as in this case, be cutting a stricture where really none existed.

In the present case, after this usual operation by incision, so as not to open the sac, Mr. Stanley found he could still make no impression on the hernia. He then, as it would not go up, opened the sac, when the cause of the strangulation was apparent in the shape of a quantity of fluid, fully ten ounces, in the sac, joined to a merely thickened neck to the sac, the latter preventing the fluid getting back into the abdomen, and causing constriction of the intestine, or a sort of hydrostatic pressure, equal all round.

Could this fluid have been diagnosed early, it might have been a question how it should be evacuated. The intestine, however, was healthy, which is a very cardinal point in all such operations, and as such, it was easily and satisfactorily reduced. The man had large doses of purgatives out of doors, which did not act, of course, but which, it was feared, would act now with considerable force.

Mr. Stanley and Mr. Lawrence have seen, perhaps, as many cases of hernia as any other two surgeons in Europe. We were, accordingly, very much interested in some bedside observations incidentally made by Mr. Stanley in this case, more especially as to the use of purgatives after operation. The general result, he thinks, is a curious instance of the success of arguing from false premises, or arguing in a circle, but some accident breaking up the magic ring. Mr. Stanley recollects the times of Mr. Abernethy, when a series of discussions of a grave nature arose as to the best character of purgative to be administered after hernia operation; manna, senna and salts, colocynth, croton oil, had each its doughty champion. "I have bushels of such cases," said Mr. Stanley, "where the fatal peritonitis may be traced to the drastic purge. There were regular pitched battles for the cause of Glauber's salt, elaterium, or croton oil, as the case might be, till it began to appear that the manna and magnesia men, the weak aperients, carried the day. Some one then suggested *no purgative at all:* that, I need not say now, is the right treatment. Purgative medicine is almost sure to do mischief if prescribed before the fourth day, and even then it must be a mild warm water enema."

Aug. 6th. With the exception of some cough, he progresses very favourably. —*Assoc. Med. Journ.*, Aug. 9, 1856.

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32. *Successful Operation for the relief of Internal Strangulation.*—The following case is quoted from the *Gazzetta Medica Italiana* in the *Gazette Médicale* for Dec. 1, 1855.

A robust countryman, aged 40, had congenital inguinal hernia on the left side. On September 7, 1854, he was attacked with borborygmi, which were usually premonitory of the descent of the hernia. In a short time, the hernia descended, and was attended with vomiting and violent pain. He was seen by

a medical man, who found the following symptoms: repeated vomiting, violent thirst, fever, tumefaction of the abdomen, and a small tumour in the left groin. Two bloodlettings, castor oil (which was rejected), poultices, ice, enemata, and purgatives, were all tried without effect. On Sept. 9th the symptoms continued, and he was bled again. On Sept. 12th, the vomitings continued; there was no alvine evacuation; the skin was nearly cold, and the pulse low; the countenance and spirits were depressed; the abdomen was extremely tense, the swollen intestines forming irregular projections. The left inguinal region was perfectly free and painless; the finger passed easily into the external ring. Along the left iliac fossa there was a little puffiness, but altogether less than in many other parts of the abdomen. The patient stated that, after the first two bleedings, the hernia had receded spontaneously, and that he had felt no more pain in the part. The existence of an internal strangulation was suspected; and croton oil was rubbed over the abdomen, and given internally, without any effect. In the evening, an operation was determined on.

The patient having been placed under the influence of chloroform, M. Borelli made, at the level of the left iliac fossa, a large transverse incision, at the height of about ten *centimètres* (four inches). A mass of small intestine escaped from the wound; but in this there was found no obstruction. M. Borelli then introduced nearly his whole hand into the abdomen by the side of the umbilicus, and discovered the strangulation, in the form of a very firm and tight ring encircling the intestine. This was divided by a bistoury, the intestines were replaced, and the wound in the abdomen was closed by sutures.

The operation was followed by relief from the vomiting. The distension and pain of the abdomen continued two days, during which there was no alvine evacuation. Enemata, poultices, mercurial inunction, calomel and jalap, were employed, with the result of obtaining motions. On Sept. 15th, the patient was bled twice. On Sept. 16th, the abdomen was greatly distended, and the patient's strength was much prostrated. Enemata, with castor oil, produced evacuations, which were followed by improvement in the symptoms. The patient had a relapse, which was suspected to be due to indigestion; he had also an attack of intermittent fever. He recovered from these, however, and was able to leave his bed early in October.—*Assoc. Med. Journ.*, Jan. 19th, 1856.

33. *Prolapsus Ani.* By Prof. Syme.—About three years ago Dr. Dick, of Mid-Calder, called upon me with a gentleman suffering from an enormous protrusion of the rectum, which he had been led to regard as irremediable, and which at first sight certainly appeared to be so. A slight expulsive effort brought into view the tumour, which in size and form resembled a large cocoa-nut. It had a firm consistence, rough irregular surface, dark brown colour, and coating of bloody mucus, so as to be more like a malignant growth than a simple descent of the bowel. Nevertheless, being satisfied from the history of the case that the disease was of the latter kind, I held out the prospect of beneficial treatment, and the patient readily promised submission to whatever I should propose.

The integuments round the anus being greatly relaxed and thickened, so as to constitute a number of pendulous folds, I removed all this redundant texture by repeated applications of the scissors, not in a circular direction, but pointed from the circumference towards the centre of the orifice. This would have been a painful operation if performed on a conscious patient, but, being executed under the influence of chloroform, was accomplished without suffering, and also the difficulties attendant upon involuntary straining. I then enjoined the necessity of strictly maintaining the horizontal posture, and of abstaining from food beyond what was absolutely requisite. The bowels were not disturbed for several days, and at the end of this time were evacuated without any protrusion or difficulty, in consequence, no doubt, of the intestinal coats regaining their natural condition, while the sphincter was no longer impeded in the discharge of its duty. In the course of a few weeks, the patient felt able to resume his service in an office of the government in London, where he has ever since been employed, and felt so well as to enter into the matrimonial